Appendix 1

EXPOSURE ASSESSMENT FORM

Service Unit Respiratory Protection Program Policy
Attachment - A, Departmental Hazard Survey
Name of Dept. Department
Month Day , 2000

Job Title or Trade Affected	Hazard(s) Identified	Type Respirator Required	Cartridge Needed	Cartridge Replacement	Color/Band of Cartridge	Notes

Appendix 2

RESPIRATOR QUALITATIVE FIT TEST RECORD

RESPIRATOR QUALITATIVE FIT TEST RECORD
29 CFR 1910.134 (MANDATORY)

Employee:_____

Job Title/Description:_____

Department:_____
Duty Phone:_____

Respirator Selected:_____
Manufacturer:_____
NIOSH Approval Number:_____
Model:_____
Size:_____

Fit Testing Method Used: Qualitative

Conditions Which Could Affect The Fit: Please Circle:

Clean Shaven	1-2 Day Beard Growth	2 + Days Beard Growth
Moustache	Facial Scar	Glasses
Dentures	Other(s):_____	

Fit Checks: Please Circle:

Negative Pressure:	PASS	FAIL	NOT DONE
Positive Pressure:	PASS	FAIL	NOT DONE

Sensitivity Test Used:_____ #Squeezes of Bulb Nebulizer_____

Comments:_____
_____

Employee Acknowledgment of Test Results:

Employee Signature:_____ Date:_____

Test Conducted By: _____ Date:_____

Appendix 3

PARTICULATE RESPIRATOR MEDICAL EVALUATION

Particulate Respirator Medical Evaluation

This questionnaire is used in determining whether or not you have a medical condition that may affect your ability to wear a respirator. We anticipate being able to approve most people for respirator use based on this questionnaire alone. In some cases we may ask for more information. Fit testing is also required and is done separately. All medical information is considered confidential.

All Information Must Be Completed For Respirator Approval

Name	Age	SSN#
Department	Work Extension	Today's Date

When using a respirator, work is:	Shifts per week respirator is worn:	Time respirator worn during shift:
a. ☐ Light b. ☐ Moderate c. ☐ Heavy	a. ☐ Less that 1 b. ☐ 1-4 c. ☐ Almost every shift	a. ☐ Less than 1 hour b. ☐ 1-5 hours c. ☐ 5-12 hours

Medical History

Has a doctor ever told you that you have had any of the following?

	Yes	No		Yes	No
Angina			Diabetes Treated with Insulin		
Heart Attack			Lung Disease		
Epilepsy or Seizures			Emphysema		
High Blood Pressure			Asthma/Hayfever/Nose Problems		

Explain "YES" answer. (may use back of form)
(If positive smoking history: # packs/day: # years smoked: If quit, when:

Are you currently taking any medications? Please Circle: Yes / No	Please List (may use back of form):

Review of Symptoms

	Yes	No
Are you short of breath at rest?		
Do you get short of breath at work?		
Do you get short of breath?		
Do you get chest pain with certain activities?		
Do you have medical problems that might interfere with respirator use?		
Have you ever had problems wearing a respirator?		

Explain "YES" answer (may use back of form).

Employee's Signature:	Date:

Medical Department Use Only

☐ Approved ☐ Approved with Restrictions ☐ Denied ☐ More Information Needed

Recommendations / Remarks:

Physician's Signature:	Date:

Appendix 4

RESPIRATOR MEDICAL EVALUATION QUESTIONNAIRE

Respiratory Protection - Medical Clearance Evaluation Questionnaire
_____Service Unit, Phoenix Area Indian Health Service
OSHA Standard 29 CFR 1910.134 Appendix C

Section I **- Employer Section is filled out by the supervisor and forwarded to the employee to fill out section IV and V (if full facepiece or SCBA).**

Employee's Name: _____ Social Security #: _____-_____-_____

Employee's Job Title: _____ EMF Number: _____

Supervisor's Name: _____ Department: _____

Employee's work phone #: _____-_____ Employees work hours/shift: _____ to _____

Circle type of respirator employee will use: UVEX / 1/2 mask / PAPR / Full Facepiece / SCBA / Other - list_____

Type of filter used on respirator (circle all that apply): N / P / R

Level of work while using respirator (circle one): light / moderate / heavy / strenuous

Extent of respirator use (circle one): daily / occasionally-more than once/week / infrequently

Time of respirator use per day in hours: _____ hours

Special work considerations (i.e., high places, other protective cloths, heat exposure, etc.):

_____

_____

Section II **- Healthcare Providers Evaluation Section is filled out when section s I, IV, & V (if necessary) are completed.**

Completed Medical Clearance Evaluation Questionnaire (both employer and employee sections) were reviewed by):

Printed Name: _____, Title: _____

Is additional information needed to evaluate this employee for respirator use: Yes / No

If yes, please contact the employee or supervisor to obtain any additional information.

Is a medical appointment needed for further evaluation of employee: Yes / No

If yes, please schedule employee medical evaluation (exam, tests, etc.) before completing this evaluation.

Respirator use approval class (circle one):
1. No restrictions on respirator use
2. Some specific use restrictions (list below)
3. No respirator use permitted

Restrictions/Comments:

_____

_____

Review question 16 "employee section"; if answered yes, please review findings/recommendations with the employee and provide the employee with a copy of the completed form.

Evaluating Healthcare Professionals Signature: _____, Date of review: ____/____/____

When this form is completed, the employee can be fit with a respirator if approved.

Section III **- Fit Testing Section to be completed by individual who conducts the fit testing.** Date Fit Test Performed: ____/____/____

Performed by: _____ Title: _____ Type of test conducted: Saccharin / Smoke / Bitrex

Sensitivity Test: Passed / Failed Positive Pressure Test: Passed / Failed Negative Pressure Test: Passed / Failed

Clean Shaven: Yes / No Model of respirator: _____ Size of respirator: _____

Fit Test Results: Passed / Failed Instructions on use/limitations of the respirator given to employee: Yes / No

This completed form is to be filed in the Employee's Medical File (EMF).

Section IV **- Employee Section - All employees must fill out this section and forward to healthcare professional for review.**

1. Can you read: Yes / No If No - Name of interpreter: _____

2. Sex: Male / Female 3. Height: ____ft. ____ in. 4. Weight ____ lbs. 5. Age ____ years

6. Has your employer told you how to contact the healthcare professional who will review this questionnaire: Yes / No

7. Have your worn a respirator before (circle one): Yes / No If so what types: _____

8. Do you *currently* smoke (circle one): Smoked in last month / Used to Smoke / Never Smoked

9. Have you *ever had* any of the following conditions?
   a. Seizures (fits): Yes / No
   b. Diabetes: Yes / No
   c. Allergic Reactions that interfere with breathing: Yes / No
   d. Claustrophobia (fear of closed-in places): Yes / No
   e. Trouble Smelling odors: Yes / No

10. Have you *ever had* any of the following pulmonary or lung problems?
   a. Asbestosis: Yes / No
   b. Asthma: Yes / No
   c. Chronic Bronchitis: Yes / No
   d. Emphysema: Yes / No
   e. Pneumonia: Yes / No
   f. Tuberculosis: Yes / No
   g. Silicosis: Yes / No
   h. Pneumothorax (collapsed lung): Yes / No
   i. Lung Cancer: Yes / No
   j. Broken ribs or any other chest injuries or surgeries: Yes / No
   l. Any other lung problems: Yes / No

11. Do you *currently* have any of the following symptoms of pulmonary or lung illness?
   a. Shortness of breath (during work, while walking, or other times): Yes / No
   b. Coughing that produces phlegm (thick sputum): Yes / No
   c. Coughing that wakes you early in the morning: Yes / No
   d. Coughing that occurs mostly when you are lying down: Yes / No
   e. Coughing up blood in the last month: Yes / No
   f. Wheezing (home or at work): Yes / No
   g. Chest pain when you breathe deeply: Yes / No
   h. Any other symptoms you think may be related to lung problems: Yes / No

12. Have you *ever had* any of the following cardiovascular or heart problems?
   a. Heart attack: Yes / No
   b. Stroke: Yes / No
   c. Angina: Yes / No
   d. Heart Failure: Yes / No
   e. Swelling in your legs or feet (not caused by walking): Yes / No
   f. Heart arrhythmia (heart beating irregularly): Yes / No
   g. High blood pressure: Yes / No
   h. Any other heart problem that you've been told about: Yes / No

13. Have you *ever had* any of the following cardiovascular or heart symptoms?
   a. Frequent pain or tightness in your chest: Yes / No
   b. Pain or tightness in your chest during physical activity: Yes / No
   c. Pain or tightness in your chest that interferes with your job: Yes / No
   d. Heart skipping or missing a beat (during last two years): Yes / No
   e. Heartburn or indigestion that is not related to eating: Yes / No
   f. Any other symptoms related to heart or circulation problems: Yes / No

14. Do you *currently* take medication for any of the following problems?
   a. Breathing or lung problems: Yes / No
   b. Heart trouble: Yes / No
   c. Blood pressure: Yes / No
   d. Seizures (fits): Yes / No

15. If you've used a respirator, have you *ever had* any of the following problems? (If you've never used a respirator, go to question 16)?
   a. Eye irritation: Yes / No
   b. Skin allergies or rashes: Yes / No
   c. Anxiety: Yes / No
   d. General weakness or fatigue: Yes / No
   e. Any other problem that interferes with your use of a respirator: Yes / No

16. Have you had any facial changes (broken nose or jaw, 10 pound weight change, dentures, etc.) in the last year? Yes / No

17. Would you like to talk to the healthcare professional who will review this questionnaire, or like to receive a copy: Yes / No

18. Employees signature: _____, Job Title: _____ Date signed: ____/____/____

Respiratory Protection - Medical Clearance Evaluation Questionnaire
Supplemental Employee Section - For Full Facepiece or SCBA Respirator Use

Section V **- Employee's that will be using a full facepiece respirator or SCBA will fill out this section.**

The following questions must be completed by every employee who has been selected to use either a full-facepiece respirator or a self-contained breathing apparatus (SCBA). For employees who have been selected to use other types of respirators, answering these questions is voluntary.

1. Have you *ever lost* vision in either eye (temporarily or permanently): Yes / No

2. Do you *currently* have any of the following vision problems?
   a. Wear Contact lenses? Yes / No
   b. Wear Glasses? Yes / No
   c. Color Blind? Yes / No
   d. Any other eye or vision problem: Yes / No

3. Have you *ever had* an injury to your ears, including a broken ear drum: Yes / No

4. Do you *currently* have any of the following hearing problems?
   a. Difficulty hearing: Yes / No
   b. Wear a hearing aid: Yes / No
   c. Any other hearing or ear problem: Yes / No

5. Have you *ever had* a back injury: Yes / No

6. Do you *currently* have any of the following musculoskeletal problems?
   a. Weakness in any of your arms and legs: Yes / No
   b. Back pain: Yes / No
   c. Difficulty fully moving your arms and legs: Yes / No
   d. Pain or stiffness when you lean forward or backward at the waist: Yes / No
   e. Difficulty fully moving your head up or down: Yes / No
   f. Difficulty fully moving your head side to side: Yes / No
   g. Difficulty bending at your knees: Yes / No
   h. Difficulty squatting to the ground: Yes / No
   i. Difficulty climbing a flight of stairs or a ladder carrying more than 25 lbs: Yes / No
   j. Any other muscle or skeletal problem that interferes with using a respirator: Yes / No